

# U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 6 1960

-60-030323

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 100

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Harrison</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Bethany</u>		Length of stay in lb <u>6 Days</u>		c. CITY OR TOWN <u>Blytheedale</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Noll Memorial Hosp</u>		Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James William Wilson</u>				4. DATE OF DEATH Month Day Year <u>August 25, 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12, 1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>		11. BIRTHPLACE (City and state or country) <u>Macon Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S</u>	
13a. FATHER'S NAME <u>David Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Ella Mae Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>LOST</u>		17. INFORMANT Address <u>Ella Mae Wilson Blytheedale, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure.</u> DUE TO (b) <u>Arteriosclerotic Heart Disease.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Benign Prostatic Hypertrophy</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>8-20-60</u> to <u>8-25-60</u> and last saw him alive on <u>8-25-60</u> Death occurred at <u>7:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Albert F. Tibbe</u> (Degree, or title) M.D.		22b. ADDRESS <u>Bethany, Mo.</u>		22c. DATE SIGNED <u>8-29-60</u> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 28, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Blytheedale, Mo</u>			
24. FUNERAL DIRECTOR <u>Harold W. Boggs - Eaglewood, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-29-1960</u>		26. REGISTRAR'S SIGNATURE <u>Gella Mayes</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Herald W. Boggess

Licensed Embalmer No. 476

P. O. Address Eagle

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.